

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042709

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

1-1-18 1963

3000

364

1. PLACE OF DEATH a. COUNTY <u>Adair</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Adair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Kirksville</u>		c. CITY OR TOWN <u>Novinger</u>	
Length of stay in 1b <u>6 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Laughlin</u>		d. STREET ADDRESS <u>none</u>	
3. NAME OF DECEASED (Type or print) First <u>Cleo</u> Middle <u>Sprang</u> Last <u>Haley</u>		4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1963</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11a. FATHER'S NAME <u>Sprang, Sherman</u>		11b. MOTHER'S MAIDEN NAME <u>Burchett, Georgia</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) <u>No</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Mrs. D.E. Grisamer</u>		18. NAME OF HUSBAND OR WIFE <u>Fort Collins, Colo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 Min.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from <u>11/4/63</u> to <u>11/10/63</u> and last saw her <u>6:15 A.</u> alive on <u>11/10/63</u> Death occurred at <u>11/10/63 6:15 A.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Richard P. Talbot</u> (Degree or title)		22b. ADDRESS <u>Laughlin Hospital</u>	
22c. DATE SIGNED <u>11-11-63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-13-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Novinger</u>	
23d. LOCATION (City, town, or county) <u>Novinger, Mo.</u>			
25. DATE RECD. BY LOCAL REG. <u>Nov. 11, 1963</u>		26. REGISTRAR'S SIGNATURE <u>Doris W. Patliff</u>	
27. FUNERAL HOME, ADDRESS <u>Dee Riley Funeral Home, Inc.</u> <u>415 North Franklin</u> <u>Kirksville, Missouri</u>			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300 Rev. 4/59	DATE AMENDED		
1 6017			
2 0010			
3			
4 1			
5 2			
6			
7 0			
8 2			
9 4/201			
10			
11			
12 3-2			
13 1-0			

(Licensed Embalmer's Statement on Reverse Side)

407010-011

DEC 26 1963

RICHARD P. VALUICK, D.D.

Permit issued Nov. 11, 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Larry Jackson

Licensed Embalmer No. 5158

P. O. Address Kirksville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.